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Congressional Committees

Subject: *Military Personnel: Guidance Needed for Any Future Conversions of Military Medical Positions to Civilian Positions*

Since September 11, 2001, the high pace of military operations has placed significant stress on U.S. operating forces. In late 2003, the Department of Defense (DOD) reported that several studies had found that tens of thousands of military personnel were performing tasks that were not military essential and that these tasks could be performed more cost effectively by civilian or private-sector contract employees. To address this matter, DOD, in fiscal year 2004, began a multiyear initiative to convert military positions, including military health care positions,¹ to federal civilian or contract positions.²

Within DOD, the Office of the Under Secretary of Defense, Personnel and Readiness (USD, P&R), has overall responsibility for issuing guidance on manpower management, which includes guidance related to determining the least costly mix of military, civilian, and contract personnel.³ Additionally, the Under Secretary of Defense (Comptroller) (USD (C)) and the Director, Program Analysis and Evaluation (PA&E) play key roles in determining the costs of military, civilian, and contract personnel. For example, the USD(C) is responsible for developing the composite pay rates used in developing military and civilian personnel budgets and PA&E provides leadership in developing and promoting tools, data, and methods for analyzing allocation of resources. USD, P&R also has responsibility for the Defense Health Program, which provides health care to over 9 million beneficiaries—including military servicemembers and retirees and their families and survivors. This program had estimated costs of \$21 billion for fiscal year 2007 and DOD officials anticipate further significant growth in these health care costs. In fact, the costs associated with

¹For the purposes of this report, military health care positions include medical, dental, and other personnel associated with the delivery of health care in the Defense Health Program.

²Hereafter, we will refer to federal civilian or contract positions as “civilian positions.”

³DOD Directive 1100.4, *Guidance for Manpower Management* (Feb. 12, 2005).

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the program have doubled since fiscal year 2000 due to factors such as increased enrollment, medical inflation, and implementation of the TRICARE for Life program.⁴

In recent years, however, questions have surfaced about the potential effects of DOD's planned conversions on the Defense Health Program. Congress addressed these questions in the National Defense Authorization Act for Fiscal Year 2006⁵ by prohibiting the military departments from performing any further military to civilian conversions until the service secretaries' submitted certifications that such conversions would not increase costs or decrease access to or quality of care. The act also required us to report on the potential effects on the Defense Health Program of converting military health care positions to civilian positions—to include impacts on medical readiness, recruitment and retention, and cost associated with the conversions. In our May 2006 report,⁶ we stated that the military departments⁷ did not expect conversions to have any effects on medical readiness, quality of care, recruitment and retention of military personnel, or access to care. However, we noted at that time that it was unknown whether these conversions would increase or decrease costs to DOD, primarily because the methodology each of the departments considered using in its certification did not include the full cost of military personnel. At that time, PA&E was developing a methodology to account for both the direct and indirect costs for military personnel, including costs for training and recruiting. Accordingly, we recommended, among other things, that the secretaries of the military departments coordinate their certifications with PA&E to consider full costs for military personnel and for civilian or contract personnel when reporting to Congress. DOD generally concurred with the recommendations, but commented that it was unclear when the PA&E cost methodology would be finalized and available for use by the military departments. As of December 6, 2007, PA&E was still working to finalize the full cost methodology and responsible officials said they did not expect it to be final until June or July of 2008. We continue to believe the military departments should account for the full cost of military health care positions converted or planned for conversion as we recommended.

In October 2006, the John Warner National Defense Authorization Act (NDAA) for fiscal year 2007⁸ revised the requirements for the military departments to certify and report on planned conversions of military medical and dental positions to civilian medical and dental positions. Under this law, the Secretary of a military department

⁴Medical inflation refers to an increase in the cost of medical services such as prescription drugs, medical supplies, physician services, dental services, inpatient care, and outpatient care. TRICARE for Life is supplemental coverage for TRICARE beneficiaries, who are entitled to Medicare Part A and have Medicare Part B coverage, regardless of age. It serves as a secondary insurance policy to pay for medical costs not paid by the beneficiaries' Medicare coverage.

⁵Pub. L. No. 109-163, §744 (2006).

⁶ GAO, *Military Personnel, Military Departments Need to Ensure That Full Costs of Converting Military Health Care Positions Are Reported to Congress*, GAO-06-642 (Washington, D.C.: May 1, 2006).

⁷The military departments consist of the Army, the Navy, and the Air Force. The Navy is responsible for providing medical and dental support to the Marine Corps.

⁸Pub. L. No. 109-364, §742 (2006).

may not convert any military medical or dental positions to civilian positions until the Secretary submits a certification to the congressional defense committees that conversions will not increase cost or decrease quality of care or access to care. Furthermore, the act required that each certification include a written report that addressed, among other things:

- the methodology used by the Secretary in making the determinations necessary for the certification;
- the number of positions, by grade or band and specialty, planned for conversion;
- an analysis showing the extent to which access to care and cost of care will be affected;
- a comparison of the full costs for the military medical and dental positions planned for conversion with the estimated full costs for the civilian medical and dental positions that will replace them, including expenses such as recruiting, salary, benefits, training, and any other costs the department identifies; and
- an assessment showing that the military medical or dental positions planned for conversion are in excess of those needed to meet medical and dental readiness requirements

In addition, the act required the military departments to submit their certification for fiscal year 2008⁹ at the time the President's Budget was submitted to Congress (Feb. 5, 2007), resubmit their certifications and reports for fiscal year 2006 conversions, and follow certain special requirements for fiscal year 2007 certifications. Enclosure I has the detailed reporting requirements for the certification reports, along with the specific special requirements for the fiscal year 2007 certifications.

All of the military departments submitted their certification packages to Congress at various times—in some cases several months after the President's Budget had been submitted to Congress on February 5, 2007. For example, the Air Force's packages for fiscal years 2007 and 2008 were submitted April 17 and 12, 2007, respectively; while the Navy's fiscal years 2007 and 2008 certification packages were submitted July 10, 2007. The Army's fiscal year 2007 certification was submitted June 4, 2007; while the fiscal year 2008 certification was submitted October 9, 2007. In addition, the military departments' certification packages varied in terms of format and content. Specifically, each department created its own format for its certification; two included the certification as a stand-alone document, while one provided a separate certification document and a report with several pages to address each of the requirements under the law. For example, the Navy's packages included a 1-page certification letter along with a separate 11-page report with sections corresponding to the 8 reporting requirements of the law. The Army, on the other hand, submitted a 1-page certification letter with 1 paragraph to address all of the 8 reporting requirements.

In addition to the mandate for the military departments, the act also required that we review any certifications and reports that the military departments had submitted to

⁹The military departments' submissions for fiscal year 2008 also contained information related to planned conversions for fiscal year 2009.

the congressional defense committees. For this report, we reviewed the extent to which the military departments addressed the reporting requirements of the 2007 National Defense Authorization Act. In addition, we reviewed the extent to which the military departments (1) had documentation to support their assessments of the impact of conversions on readiness, cost, quality of care, access to care, and recruitment/retention of military personnel; and (2) converted or planned to convert military medical and dental positions during fiscal years 2005 to 2009. This report documents and updates information that we provided to your offices in an interim status briefing on October 5, 2007. Enclosure II contains the updated briefing slides.

To address our objectives, we interviewed officials and obtained pertinent documents, reports, and information related to the military medical to civilian conversion programs from each of the offices of the Surgeons General for the Army, Navy, and Air Force; the Office of the Secretary of Defense for Personnel and Readiness; Director for PA&E; and the TRICARE Management Activity within the Office of the Assistant Secretary of Defense for Health Affairs (ASD (HA)). Specifically, to determine the extent to which the military departments had addressed the certification and reporting requirements of the 2007 National Defense Authorization Act, we obtained and reviewed each of the military departments' certification letters and reports submitted to Congress. To determine the extent to which the military departments had documentation to support their assessments of the potential effects of planned conversions, we reviewed documentation supporting the military departments' assessments of the potential effects of conversions on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental positions. To determine the extent to which the military departments have developed and implemented plans to convert military medical positions, we obtained documents and interviewed officials from the offices of the Surgeons General for the Army, the Navy, and the Air Force concerning their department's actual conversions for fiscal years 2005 through 2007, planned conversions for fiscal years 2008 and 2009, and the current status of efforts to hire civilian employees to fill converted positions. Further details on our scope and methodology can be found in enclosure III. We conducted this performance audit in accordance with generally accepted government auditing standards from August 2007 to February 2008.¹⁰ Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Summary

Although each of the military departments submitted certification packages to Congress that addressed or partially addressed most of the reporting requirements of

¹⁰Toward the end of our review, the National Defense Authorization Act for Fiscal Year 2008 was passed. Public Law Number 110-181, §721 (2008) prohibits all conversions of military medical positions to civilian positions beginning October 1, 2007, and extending until September 30, 2012. The Act also repeals the certification requirement set forth in section 742 of the John Warner National Defense Authorization Act for Fiscal Year 2007.

the law, none of the departments' certifications addressed all of those requirements. For example, each department identified the methodology it had used to reach its certification decisions, and each reported that the positions it planned to convert were in excess of those needed to meet military readiness requirements. On the other hand, none of the military departments provided an analysis of the impact the conversions would have on the cost of care—within either the direct care system or the purchased care system. Officials from each of the military departments told us that their certification packages did not address the cost of care because it would be difficult to attribute specific changes in such costs within either system given that the cost growth within the Defense Health Program results from several factors, such as increased enrollment in beneficiaries, medical inflation, and implementation of the TRICARE for Life program. In response to the requirement to use a full cost methodology, the Navy's methodology was the only one that addressed the specific factors identified by the act—including training and recruiting¹¹—for positions planned for conversion for fiscal years 2007 and 2008.¹² The Air Force and the Army relied on composite military rates, instead of using a full cost methodology like the one PA&E is developing.¹³ These composite rates did not include all of the required cost factors, such as training and recruiting costs. Responsible officials from both the Air Force and the Army stated that the composite rates provided by USD (C) represented the funding associated with the converted positions at the time and that, because the development of the PA&E methodology was not complete, they used the composite rates for their analysis. However—as we reported in May 2006—without accounting in their certifications to Congress for the full costs of military health care positions that have been converted or are planned for conversion, the military departments cannot accurately compare the costs of military and civilian positions, and Congress cannot be assured that the certified conversions will not increase DOD's cost of care.

In their certification packages, the military departments identified or provided support for some of the potential effects of conversions; however, they did not provide us with analysis or with additional documentation to support all of their assessments of potential effects. While the statute requiring certifications does not require the departments to provide documentation supporting their assessments, such additional information would provide Congress with a better understanding of the certification packages. Although the USD, P&R has issued memoranda urging the military departments to comply with the certification requirements and advising them on implementing conversions, this guidance did not address how to conduct the cost analysis, how to comply with reporting requirements, or how to document the

¹¹ According to The John Warner National Defense Authorization Act for Fiscal Year 2007, full cost would include expenses for recruiting, salary, benefits, training, and any other costs the department identifies.

¹² Specifically, the Navy applied a percentage factor recommended by OSD (PA&E) to approximate the full costs of military and civilian personnel.

¹³ The Air Force did use a more complete cost methodology for fiscal year 2008 conversions, which included training costs for a portion of its fiscal year 2008 conversions. In October 2007, Army officials stated that they had completed work on a full cost methodology for certifications prepared after fiscal year 2008.

analyses of potential effects of conversions including the key assumptions. In addition, officials within the USD, P&R and the TRICARE Management Activity stated that such guidance was not issued because the law required the secretaries of the military departments—not the Secretary of Defense—to submit the certifications. These OSD officials acknowledged, however, that leadership was needed in this area at the OSD level. As stated previously, under DOD's manpower management directive, OSD (P&R) is responsible for issuing guidance on manpower management, which would include guidance related to determining the least costly mix of military, civilian, and contract personnel. Specifically, regarding the military to civilian conversion certifications, we found that each of the military departments provided documentation to support its assessment of the impact of conversions on medical readiness,¹⁴ along with documentation to demonstrate how their cost comparisons were performed. On the other hand, we found that even though each of the departments stated that planned and completed conversions would not have a negative impact on access to care, only the Navy provided an analysis of patient waiting times for medical appointments to support this conclusion. Air Force and Army officials told us that they based their assertion that conversions would not decrease access to care on the assumption that converted military positions would be filled on a one-to-one basis by qualified civilian employees, and thus qualified providers would be available to prevent problems with access to care. Regarding the quality of care received by beneficiaries, all of the military departments stated that quality of care would not be affected by conversions because the civilians being hired would be required to have the same qualifications, credentials, and licenses as the military personnel who had held the positions being converted. However, none of the departments provided documentation—for example, an assessment that quality of care performance measures¹⁵ had not been negatively impacted by conversions—to demonstrate this. Similarly, all of the military departments stated that they did not expect conversions to negatively impact recruitment or retention of military personnel, but none provided any data supporting this view. Officials from each of the military departments stated that the impact of conversions on access to care, quality of care, and recruitment/retention of military personnel would be difficult to isolate and document because many factors would influence any performance metric used to assess any impacts. These factors include the cost growth discussed earlier, increased number of beneficiaries covered by the defense health program, as well as deployments and temporary duty travel. However, federal internal control guidance states that appropriate documentation should be maintained for significant events, and internal controls are designed to provide reasonable assurance concerning compliance with applicable laws and regulations.¹⁶ Without guidance from OSD to

¹⁴Each of the military departments stated that medical readiness was based on DOD's most recent Medical Readiness Review (MRR) and that planned conversions are in excess of those positions required for the readiness mission. However, we have not reviewed the assumptions and data used in the conduct of the MRR.

¹⁵In addition to credentialing and licensing, these performance measures would include how well the health care system performed with respect to measurable processes and outcomes of care for clinical performance measures and in response to surveys to measure how well the health care system is viewed by the beneficiaries, military leadership, and Congress.

¹⁶See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

direct the military departments in preparing their certifications, particularly in the area of documenting and maintaining a record of the assessments of the impacts of conversions, the certification packages would not provide Congress with a complete understanding of the potential impacts of conversions. Consequently, Congress would not have reasonable assurance that conversions will not increase the cost of care, decrease access to care, or decrease quality of care. Moreover, Congress would not have all the information necessary to make informed decisions about current and future conversion of military medical personnel.

To date, the military departments have converted or have plans to convert almost 10,000 military medical and dental positions to federal civilian/contract positions from fiscal year 2005 through fiscal year 2009. As shown in table 1 (enclosure II), the Army, Navy, and Air Force converted a total of 5,305¹⁷ military positions to civilian positions from fiscal year 2005 through 2007. Notably, only 152 physician and 11 psychologist positions were included in the fiscal year 2005 to fiscal year 2007 conversions (see enclosure IV for a detailed distribution of converted positions). In addition, the military departments plan to convert another 4,426¹⁸ positions during fiscal years 2008 and 2009. Similarly, only 86 physician and 12 psychologist positions were planned for conversion in fiscal years 2008 and 2009; none of the physician or psychologist positions planned for conversion are Army medical positions. According to DOD and military department officials, success in hiring civilian replacements for converted military medical and dental positions is dependent on a number of factors, including the availability of qualified civilian applicants, competitiveness of proposed salaries, economic conditions in the affected areas, and the lead time needed to hire civilian employees. As shown in table 2, (enclosure II), each of the military departments has had varying degrees of success in hiring civilians to fill converted military positions. For example, the Navy (the only military department with conversions in fiscal year 2005) has hired 94 percent of the planned hires. Each of the departments has hired about three-fourths of the planned hires for the fiscal year 2006 conversions. Success in hiring civilian replacements for fiscal year 2007 varied widely, from 9 percent for the Navy to 85 percent for the Army.

In January 2008, as we were preparing to issue this report, the National Defense Authorization Act for Fiscal Year 2008 was passed.¹⁹ The Act contains language that

¹⁷In our May 2006 report, we reported a total 5,507 conversions for fiscal year 2005 through 2007. The reduction in conversions resulted from a reevaluation of conversions while the departments were developing their certifications. For this report, there is a difference between the number of positions converted (5,305) and the detailed list of converted positions by type of position and grade (5,351)—a total of 46 positions. This resulted from changes in the number of positions certified for fiscal year 2006 by the Army and Air Force. At the time of recertification, a revised detailed list of converted positions was not provided to Congress.

¹⁸For fiscal year 2008, the Army certified 438 medical and dental positions within the Defense Health Program for conversion. The Army is converting an additional 300 positions within the Defense Health Program that are administrative and were not included in the certification. In addition, there is a difference between the positions planned for conversion (4,426) and the detailed list of converted positions by type of position and grade (4,417)—a total of 9 positions. This resulted because 9 positions were not included in the Army's detailed list of conversions for fiscal year 2009.

¹⁹The National Defense Authorization Act for Fiscal Year 2008, Pub. L. No. 110-181, §721 (2008).

would establish a statutory moratorium on converting any military medical and dental positions to civilian positions from October 1, 2007, through September 30, 2012.²⁰ According to DOD and military department officials, this prohibition could negatively affect the department's ability to provide health care services. However, we received limited documentation supporting these assertions. For example, these officials told us that, once a position has been selected for conversion, it is no longer included in recruiting targets. They further stated that if a military department, in the future, restores the position to a military position, it will have to reinitiate efforts to recruit and train military personnel; this could take years and could negatively affect access to care, quality of care, and the military departments' capability to provide services in key areas such as mental health treatment and surgical support. We did not evaluate these assertions.

Conclusions

While the military departments are well under way in converting almost 10,000 military medical positions to civilian positions and have generally addressed the reporting requirements of the law, Congress lacks information from the departments that would help it make decisions on current and future conversions. Although the National Defense Authorization Act for Fiscal Year 2008 places a statutory moratorium on conversions from October 1, 2007, through September 30, 2012, the accelerated growth of the Armed Forces through fiscal year 2010 and the sustained growth of the Defense Health Program will continue to tax the military health system in several areas, including manpower management. As a result, the issue of converting military medical and dental positions to civilian positions might arise again in the near future. Accordingly, we continue to believe that our previous recommendation for the departments to use a consistent, full cost methodology, like that suggested by OSD's PA&E, in any future conversion certifications has merit. Without clear guidance on the use of such a methodology, the departments would be unable to assure Congress that conversions will not increase the cost of medical care. Moreover, without clear guidance on documenting information about, for example, the departments' assessments of the potential effects of conversions on the quality of care, the departments may be unable to support their assessments. If such conversions are to be done, it will be important for Congress to receive sufficient information from the military departments to provide assurances that planned conversions will not increase cost or decrease access to care or quality of care.

Recommendations for Executive Action

To help ensure that the military departments provide Congress with reasonable assurances that any future conversions would not increase cost or decrease access to care or quality of care, we recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in coordination with the Under Secretary of Defense, Comptroller, the Director, Program Analysis and Evaluation,

²⁰Section 721 of the Act also states that in the case of any military medical or dental position that is converted to a civilian medical or dental position during the period beginning on October 1, 2004, ending on September 30, 2008, if the position is not filled by a civilian by September 30, 2008, the Secretary of the military department concerned shall restore the position to a military medical or dental position that can be filled only by a member of the Armed Forces who is a health professional.

the Assistant Secretary of Defense for Health Affairs, and the Service Secretaries, to develop operating guidance for the military departments to use when justifying future conversions of military medical and dental positions to civilian positions. This guidance should stipulate requirements to

- use a consistent full cost methodology for comparing the cost of military and civilian personnel as we had recommended in our May 2006 report and
- provide documentation to support assertions about the potential effects of planned conversions on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental personnel.

Agency Comments and Our Evaluation

DOD provided written comments on a draft of this report and generally concurred with our recommendations.

In commenting on our draft, DOD supported our recommendation to develop operating guidance that stipulates requirements to use a consistent full-cost methodology and to provide documentation to support assertions regarding the potential effects of planned conversions. DOD noted, however, that using a full-cost methodology to account for the cost of military personnel may have the consequence of making conversions even more compelling, because the cost of military manpower would be even more expensive as compared with civilian manpower. We recognize that using a full-cost methodology will increase the cost of military manpower used in the conversion decision-making process; however, the same full cost principles would also apply to determining the associated cost of civilian manpower. As a result, we continue to believe it is important that the military departments provide Congress with the most accurate comparative costs for converting military health care positions to civilian positions. In addition, DOD noted that the USD (C) and the Director, PA&E, along with USD (P&R) and ASD (HA) have responsibility to develop the tools and guidance necessary for determining the costs of military, civilian, and contract personnel and should be included as responsible parties in our recommendation. We concur that it would be appropriate to include USD (C) and the Director, PA&E as responsible parties and we have revised our recommendation accordingly. In fact, our report discusses the critical role that the full-cost methodology being developed by PA&E will play in any future medical conversions. In addition, prior GAO work has identified the need for consistent cost information across the military departments and recognized recent guidance issued by USD (C) regarding comparable cost estimates to support military to civilian conversions. Considering the many organizations within DOD that play key roles in military to civilian conversions, we believe that consistent leadership from the USD, P&R level is essential to the success of any future conversion efforts.

Finally, while DOD agreed that the military departments should provide the rationale for their conclusions and assertions as appropriate, it noted that there are many factors that affect quality, access to, and cost of health care, which are unrelated to military-to-civilian conversions and in many cases it is impossible to isolate the impact of conversions. It further noted that the Department routinely rotates military

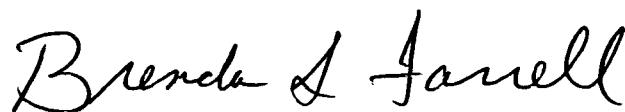
medical and dental personnel at military treatment facilities (MTFs) to other assignments within DOD and replaces civilian personnel who retire or separate without adverse consequences to health care delivery. As a result, the department stated that it is not unreasonable for the Military Departments to presume that quality and access to care will not be adversely impacted by the conversion of military medical and dental personnel—so long as civilian replacements are fully qualified, the rate of conversion is in keeping with the military rotation rate, the fill rate of vacated positions is fairly consistent with the routine fill rates at the MTFs, and requirements for skill levels are not changed at the time of the conversions. We noted throughout our report that the military departments identified the difficulties they encountered in attempting to isolate the impact of conversions. However, the certifications provided by the military departments did not provide documentation or information to support assumptions—such as fill rates for vacated positions were fairly consistent with routine fill rates. Consequently, we continue to believe that the military departments should provide both the rationale for their conclusions and information and documentation to support the assumptions on which their conclusions are based.

DOD's comments are reprinted in enclosure V. DOD also provided technical comments, which we have incorporated in the final report where appropriate.

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We are sending copies of this report to interested congressional committees, the Secretary of Defense, and the Secretaries of the Army, Air Force, and Navy. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you have any questions about this report or need additional information, please contact me at (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in enclosure VI.



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The John Warner National Defense Authorization Act for Fiscal Year 2007 required the military departments to certify and report on planned conversions of military medical and dental positions to civilian medical and dental positions. The act required a written report with detailed requirements and included several special requirements for the fiscal year 2007 certifications, which are contained in the following excerpts from the act.

PUBLIC LAW 109-364 SECTION 742:

(a) PROHIBITION ON CONVERSIONS.—

(1) Submission of Certification.— The Secretary of a military department may not convert any military medical or dental position to a civilian medical or dental position in a fiscal year until the Secretary submits to the congressional defense committees with respect to that fiscal year a certification that the conversions within that department will not increase cost or decrease quality of care or access to care.

(2) Report on Certification.—Each certification under paragraph (1) shall include a written report setting forth the following:

(A) The methodology used by the Secretary in making the determinations necessary for the certification.

(B) The number of military medical or dental positions, by grade or band and specialty, planned for conversion to civilian medical or dental positions.

(C) The results of a market survey in each affected area of the availability of civilian medical and dental care providers in such area in order to determine whether the civilian medical and dental care providers available in such area are adequate to fill the civilian positions created by the conversion of military medical and dental positions to civilian positions in such area.

(D) An analysis, by affected area, showing the extent to which access to health care and cost of health care will be affected in both the direct care and purchased care systems, including an assessment of the effect of any increased shifts in patient load from the direct care to the purchased care system, or any delays in receipt of care in either the direct or purchased care system because of the planned conversions.

(E) The extent to which military medical and dental positions planned for conversion to civilian medical or dental positions will affect recruiting and retention of uniformed medical and dental personnel.

(F) A comparison of the full costs for the military medical and dental positions planned for conversion with the estimated full costs for civilian medical and dental positions, including expenses such as recruiting, salary, benefits, training, and any other costs the Department identifies.

(G) An assessment showing that the military medical or dental positions planned for conversion are in excess of the military medical and dental positions needed to meet medical and dental readiness requirements of the uniformed services, as determined jointly by all the uniformed services.

(H) An identification of each medical and dental position scheduled to be converted to a civilian position in the subsequent fiscal year, including the location of

Enclosure I

each position scheduled for conversion, and whether or not civilian personnel are available in the location for filling a converted military medical or dental position.

(3) Submission Deadline.—A certification and report with respect to any fiscal year after fiscal year 2007 shall be submitted at the same time the budget of the President for such fiscal year is submitted to Congress pursuant to section 1105(a) of title 31, United States Code.

(b) REQUIREMENT FOR COMPTROLLER GENERAL REVIEW.—Not later than 120 days after the submission of the budget of the President for a fiscal year, the Comptroller General shall submit to the congressional defense committees a report on any certifications and reports submitted with respect to that fiscal year under subsection (a).

(c) REQUIREMENT TO RESUBMIT CERTIFICATION AND REPORT REQUIRED BY PUBLIC LAW 109-163.—The Secretary of each military department shall resubmit the certification and report required by section 744(a) of the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109-163; 119 Stat. 3360; 10 U.S.C. 129c note.) Such resubmissions shall address in their entirety the elements required by section 744(a)(2) of such Act.

(d) SPECIAL REQUIREMENTS FOR FISCAL YEAR 2007 CERTIFICATION. --

(1) List of 2007 Planned Conversions. – The report required by paragraph (2) of subsection (a) with respect to fiscal year 2007 shall contain, in addition to the elements required by that paragraph, a list of each military medical or dental position scheduled to be converted to a civilian medical or dental position in fiscal year 2007.

(2) Resubmission Required First. – The certification and report required by subsection (a) with respect to fiscal year 2007 may not be submitted prior to the resubmission required by subsection (c).

(3) Prohibition on Conversions During Fiscal Year 2007. – No conversions of a military medical or dental position may occur during fiscal year 2007 prior to both the resubmission required by subsection (c) and the submission of the certification and report required by subsection (a).



Military Personnel: Guidance Needed for Any Future Conversions of Military Medical Positions to Civilian Positions

Briefing to Congressional Committees



Prohibition on conversions

- The secretary of a military department may not convert any military medical or dental positions to civilian positions **until** its secretary submits certification to the congressional defense committees that conversions will not increase cost or decrease quality of care or access to care.

Written report required for certifications must include:

- methodology used;
- number of positions, by grade or band and specialty, planned for conversion;
- results of market surveys determining that there are adequate civilian providers available in each affected area;
- extent to which access to care and cost of care will be affected;



Observations: NDAA Requirements (cont.)

- effects of planned conversions on recruiting and retention of uniformed personnel;
- comparison of full costs for military medical and dental positions planned for conversion with estimated full costs for civilian positions including expenses such as recruiting, salary benefits, training, and any other identified costs;
- assessment showing that military medical and dental positions planned for conversion are in excess of the military positions needed to meet medical and dental readiness requirements; and
- identification of each medical and dental position scheduled to be converted to a civilian position in the subsequent fiscal year, including location, estimated cost of conversion, and availability of civilian personnel to fill the position.



Observations: NDAA Requirements (cont.)

Deadline

- The secretaries of the military departments must submit their certifications and reports to Congress with respect to any fiscal year after fiscal year 2007 at the same time as the President's Budget for the fiscal year.



Observations: NDAA Requirements (cont.)

Additional requirements

- Secretaries are required to resubmit certifications and reports for FY 2006 conversions.
- Special requirements for FY 2007 certifications:
 - the required report must list each military medical and dental position scheduled for conversion in FY 2007,
 - certification for FY 2006 must be resubmitted before submitting certification for FY 2007, and
 - no conversions may occur during FY 2007 **until** FY 2006 certification and report is resubmitted and report for FY 2007 is submitted.



Observations: Prior GAO Report

GAO's May 2006 report¹

- Examined, among other things, the military departments' completed and planned conversions and the potential effects of conversions on the Defense Health Program.
- Found that departments do not expect conversions to have any affect on medical readiness, quality of care, recruitment and retention of military personnel, or access to care. However, it is unknown whether conversions will increase or decrease costs to the Department of Defense (DOD).
- Recommended that the secretaries of the military departments be directed to (1) coordinate their certifications with the Office of the Director, Program Analysis and Evaluation (PA&E), in order to consider full costs for military personnel and full costs for civilian or contract personnel, and (2) address in certifications the extent to which total projected costs for hiring civilian or contract personnel include both the actual cost of completed hires and anticipated costs of future hires.
- As shown later in this briefing, the military departments have implemented, to some extent, certain aspects of these recommendations.

¹GAO, *Military Personnel, Military Departments Need to Ensure That Full Costs of Converting Military Health Care Positions Are Reported to Congress*, GAO-06-642 (Washington, D.C.: May 1, 2006).



Observations: Key Questions

To address the mandate for GAO to review any certifications and reports submitted by the military departments, we reviewed the extent to which the military departments addressed the certification and reporting requirements of Public Law 109-364 § 742 pertaining to conversions of military medical and dental positions.

In addition, we reviewed the extent to which the military departments

- had documentation to support their assessments of the potential effects of conversions on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental personnel, and
- converted or planned to convert military medical and dental positions to civilian positions.



Observations: Scope and Methodology

- To address our objectives, we interviewed officials and obtained pertinent documents, reports, and information related to the military medical to civilian conversion programs from:
 - the offices of the Surgeons General for the Army, Navy, and Air Force;
 - the Office of the Under Secretary of Defense for Personnel and Readiness;
 - the Director for PA&E; and
 - the TRICARE Management Activity within the Office of the Assistant Secretary of Defense for Health Affairs.



Observations: Scope and Methodology (cont.)

- Specifically, to determine the extent to which the military departments
 - had addressed the certification and reporting requirements, we obtained and reviewed each of the military departments' certification letters and reports submitted to Congress,
 - had documentation to support their assessments of the potential effects of planned conversions, we reviewed documentation supporting the military departments' assessments of the potential effects of conversions on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental positions, and
 - have developed and implemented plans to convert military medical positions, we obtained documents and interviewed officials from the Offices of the Surgeons General for the Army, the Navy, and the Air Force concerning their departments' actual conversions between fiscal years 2005 and 2007, planned conversions for fiscal years 2008 and 2009, and the current status of efforts to hire civilian employees to fill converted positions.



Observations: Reporting Requirements

- Although each of the military departments submitted certification packages to Congress that addressed or partially addressed the requirements of the law, none of the certifications addressed all of the requirements.
- For example, in the reports submitted with the certifications:
 - each of the military departments identified the methodology used to reach certification decisions;
 - each of the military departments reported that positions planned for conversion were in excess of positions needed to meet military readiness requirements; and
 - the Navy included a full cost comparison that addressed specific factors identified by the statute.



Observations: Reporting Requirements (cont.)

- However, we noted the following:
 - None of the departments included an analysis of the impact of conversions on cost of care within both the direct care system and the purchased care system.
 - The Army and the Air Force did not include a complete, full-cost comparison for all of their planned conversions. Instead, they relied on composite military rates, which do not include all of the cost factors identified by the statute, such as training and recruiting. However, the Air Force used a cost methodology that included training costs for a portion of its FY 2008 conversions.



Observations: Supporting Documentation

- While the military departments' certification packages identified or provided support for some of their assessments of the potential effects of conversions, none of the departments provided us with analyses or additional documentation to support all of their assessments.
- Specifically, each of the military departments
 - stated that medical readiness was based on DOD's most recent Medical Readiness Review (MRR) and Army, Navy, and Air Force officials told us that their planned conversions are in excess of those required for the readiness mission. (We have not reviewed the assumptions and data used in conducting the MRR), and
 - provided support that demonstrated how its cost comparison was performed.



Observations: Supporting Documentation (cont.)

- On the other hand, all of the departments stated the following:
 - Access to care would not be adversely affected by conversions.
 - The Navy provided slides from a Navy study of access to care statistics, which showed that although access to care has decreased slightly, it continues to be within TRICARE standards.
 - Army and Air Force assessments were based on the assumption that converted positions would be filled by qualified civilians.
 - Quality of care would not be negatively affected:
 - Assessments were based on the assumption that civilian hires would have the same qualifications, credentials, and licenses as the military personnel being replaced.
 - No analysis of quality of care performance measures was provided to support this assessment.



Observations: Supporting Documentation (cont.)

- Conversions were not expected to negatively affect recruitment or retention of military personnel, but the departments provided no supporting data.
- Officials from each of the departments stated that the impact of conversions on access to care, quality of care, and recruitment/retention of military personnel would be difficult to isolate and document because many factors, such as deployment, temporary duty travel, and illness of health care providers, affect these metrics.



Observations: Conversion Plans

- In FY 2005 through 2007, the Army, Navy, and Air Force have converted a total of 5,305 military positions to civilian positions and some progress has been made in hiring the civilian replacements. Another 4,426 conversions are planned in FY 2008 and 2009.

Table 1: Number of Military Medical and Dental Positions Converted or Planned for Conversion to Civilian Positions, Fiscal Years 2005-2009

Military Department	Actual conversions ^a			Planned conversions ^b		All conversions, FY 2005-2009	
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	Total	Percent
Air Force	0	403	813	954	422	2,592	27
Army	0	977	436	438	554	2,405	25
Navy	1,772	215	689	1,036	1,022	4,734	49
Total	1,772	1,595	1,938	2,428	1,998	9,731	100
Percent of total conversions	18	16	20	25	21		

Source: GAO analysis of Air Force, Army, and Navy data

^aActual conversions represent those military medical and dental positions that have been programmed for conversion by the respective departments' medical command.

^bFor fiscal year 2008, the Army certified 438 medical and dental positions within the Defense Health Program for conversion. The Army is converting an additional 300 positions within the Defense Health Program that are administrative and were not included in the certification.



Observations: Conversion Plans (cont.)

Table 2: Number of Military Medical and Dental Conversions, Planned Hires, and Positions Filled, Fiscal Years 2005-2007

Military departments	Actual conversions	Planned hires ^a	Positions filled ^b	Percentage of positions filled
Air Force				
FY 2005	0	0	0	0
FY 2006	403	403	299	74
FY 2007	813	813	483	59
Total	1,216	1,216	782	64
Army				
FY 2005	0	0	0	0
FY 2006	977	977	716	73
FY 2007	436	436	370	85
Total	1,413	1,413	1,086	77
Navy				
FY 2005	1,772	1,323	1,260	94
FY 2006	215	128	102	80
FY 2007	689	625	58	9
Total	2,676	2,076	1,420	68
DOD totals	4,705	3,288		70

Source: GAO analysis of Air Force, Army, and Navy data

^aPlanned hires represent the number of positions that the Army, Navy, and Air Force certified in a given fiscal year except for the Navy's FY 2005 and FY 2006 planned hires which are lower than the certified conversion due to an efficiency review that indicated the Navy did not need to hire a civilian for each of the converted positions.

^bPositions filled represents the most recent information provided by the services.



Observations: Conclusions

- While the military departments are well under way in converting approximately 10,000 military health care positions to civilian positions and have generally addressed the reporting requirements of the law, additional information could be helpful to Congress in making decisions on current and future military to civilian conversions within the medical community.
- Clear guidance articulating the need to use a full cost methodology, as we previously recommended, when comparing the cost of military and civilian health care positions, could assist the military departments in demonstrating the cost effectiveness of military to civilian conversions.
- Such guidance could include requirements pertaining to the documentation and retention of information related to the departments' assessments of the potential effects of conversions on cost of care, access to care, quality of care, and recruitment and retention of military personnel.
- Including such guidance could provide Congress with reports that would give them greater assurance that conversions will not increase costs or decrease access to care or quality of care.



Observations: Recommendations

To help ensure that the future certifications submitted by the military departments provide Congress with reasonable assurances that any future conversions would not increase costs or decrease access to care or quality of cost, we recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in coordination with the Under Secretary of Defense, Comptroller, the Director, Program Analysis and Evaluation, the Assistant Secretary of Defense for Health Affairs, and the service secretaries, to develop operating guidance for the military departments to use when preparing any future certifications for planned conversion of military medical and dental positions to civilian positions. This guidance should stipulate requirements to

- use a full cost methodology for comparing the cost of military and civilian personnel as we had recommended in our May 2006 report and
- provide documentation to support assertions on the potential effects of planned conversions on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental personnel.

Scope and Methodology

To address our objectives, we obtained and reviewed pertinent documents, reports, and information related to the military medical to civilian conversion programs from each of the military departments. We also interviewed cognizant officials from the offices of the Surgeons General for the Army, Navy, and Air Force; the Office of the Secretary of Defense for Personnel and Readiness; Director of Program Analysis and Evaluation; and the TRICARE Management Activity within the Office of the Assistant Secretary of Defense for Health Affairs on their military medical to civilian conversion programs.

To determine the extent to which the military departments addressed the certification and reporting requirements of the John Warner National Defense Authorization Act for Fiscal Year 2007, we obtained and reviewed each of the military departments' certification letters and supporting reports. We also identified the certification and reporting requirements of the 2007 National Defense Authorization Act. We analyzed each of the military departments' certification letters and supporting reports to determine whether they addressed the certification and reporting requirements of the 2007 National Defense Authorization Act. We also interviewed officials from each of the military departments to discuss their certification letters and supporting reports.

To determine the extent to which the military departments had documentation to support their assessments of the potential effects of planned conversions, we requested from each of the military departments the documentation they used to support their assessments of the potential effects of conversions on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental personnel. We reviewed supporting documentation from each of the military departments to identify analyses or additional data they had used to make their assessments. We also interviewed officials from each of the military departments to discuss the assumptions they used in making their assessments.

To determine the extent to which the military departments have developed and implemented plans to convert military medical positions, we obtained data from the offices of the Surgeons General for the Army, Navy, and Air Force on their actual conversions for fiscal years 2005 through 2007, their planned conversions for fiscal years 2008 and 2009, and the current status of their efforts to hire civilian employees to fill converted positions. We reviewed the data to identify, by military department, the number of actual conversions during fiscal years 2005 through 2007, the number of planned conversions for fiscal years 2008 and 2009, and the number of civilian employees hired to fill converted positions. We also interviewed officials from the offices of the Surgeons General for the Army, Navy, and Air Force concerning their departments' plans to convert military medical positions and the current status of their efforts to hire civilian employees to fill converted positions. Based on our review of the data and interviews with cognizant military officials about the data, we determined the data used in this report to be sufficiently reliable for our purposes.

Enclosure III

We conducted this performance audit from August 2007 to February 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Military Health Care Positions Converted to Civilian Positions by Type of Position and Grade, Fiscal Years 2005-2007

As shown in tables 3 and 4, the military departments have converted and plan to convert a relatively low number of officer positions. For example, during fiscal years 2005 to 2007, conversions included only 1,099 officer positions in the total of 5,351¹ positions converted from military to civilian. Included within these officer positions were 152 physician and 11 psychologist positions. Similarly, during fiscal years 2008 and 2009, planned conversions include only 684 officer positions in the total of 4,417² positions planned for conversion. Included within these officer positions were 86 physician and 12 psychologist positions.

Table 3: Military Health Care Positions Converted to Civilian Positions by Type of Position and Grade, Fiscal Years 2005-2007

Type of position/grade	Air Force	Army	Navy	Total	Percent
Officers					
Physicians	0	0	152	152	2.8
Physician assistant	3	0	39	42	1.0
Nurse	177	70	97	344	6.4
Dentist	0	32	176	208	3.9
Pharmacists	6	13	29	48	0.9
Optometrists	5	10	3	18	0.3
Psychologists	2	8	1	11	0.2
Social workers	11	6	0	17	0.3
Other medical positions ^a	24	22	91	137	2.6
Other DHP positions ^b	15	40	67	122	2.3
Total Officers	243	201	655	1,099	20.5
Total Enlisted^c	967	1,264	2,021	4,252	79.5
Total	1,210	1,465	2,676	5,351	100

Source: GAO analysis of Air Force, Army, and Navy data.

^aOther military medical positions include dieticians, physical therapists, biomedical scientists, biomedical lab officers, occupational therapists, industrial hygiene officers, environmental health officers, medical technicians, radiation specialists, medical department staff, interns, oral diagnosis staff, physiologists, emergency medical specialists, audiologists, and microbiologists.

^bOther Defense Health Program (DHP) military positions include administrative and engineering positions.

^cEnlisted positions include corpsmen, medics, aerospace, medical services, dental assistants and technicians, other medical positions, and other DHP positions.

¹ The number of converted positions for fiscal years 2005 through 2007 included in this detailed analysis varies by 46 from the certified conversion numbers presented on page 7 and in table 1 on page 28. The difference resulted because of changes in the actual number of certified conversions in fiscal year 2006 within the Army and Air Force.

² The number of positions planned for conversion in fiscal years 2008 and 2009 varies slightly from the planned conversions presented on page 7 and in table 1 on page 28. This difference resulted because nine positions within the Army's planned conversions for fiscal year 2009 were not included in the detailed list of conversions by type of position and grade.

Table 4: Military Health Care Positions Planned for Conversion to Civilian Positions by Type of Position and Grade, Fiscal Years 2008-2009

Type of position/grade	Air Force	Army	Navy	Total	Percent
Officers					
Physicians	40	0	46	86	1.9
Physician assistant	10	0	17	27	0.6
Nurse	150	15	60	225	5.1
Dentist	5	0	80	85	1.9
Pharmacists	2	1	5	8	0.2
Optometrists	5	6	4	15	0.3
Psychologists	4	0	8	12	0.3
Social workers	15	2	1	18	0.4
Other medical positions ^a	27	9	55	91	2.1
Other DHP positions ^b	31	23	63	117	2.6
Total Officers	289	56	339	684	15.5
Total Enlisted^c	1,087	927	1,719	3,733	84.5
Total	1,376	983	2,058	4,417	100

Source: GAO analysis of Air Force, Army, and Navy data.

^aOther military medical positions include dieticians, physical therapists, biomedical scientists, biomedical lab officers, occupational therapists, industrial hygiene officers, environmental health officers, medical technicians, radiation specialists, medical department staff, interns, oral diagnosis staff, physiologists, emergency medical specialists, audiologists, and microbiologists.

^bOther Defense Health Program (DHP) military positions include administrative and engineering positions.

^cEnlisted positions include corpsmen, medics, aerospace, medical services, dental assistants and technicians, other medical positions, and other DHP positions.



THE ASSISTANT SECRETARY OF DEFENSE

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HEALTH AFFAIRS

Ms. Brenda S. Farrell
Director, Defense Capabilities and Management
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

JAN 29 2008

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report, GAO-08-370R, 'Military Personnel: Guidance Needed for Any Future Conversions of Military Medical Positions to Civilian Positions,' dated January 7, 2008 (GAO Code 351087).

Thank you for the opportunity to review and comment on the draft report. Overall, I concur with draft report's findings and conclusions.

The ability to convert military positions to civilian/contractor positions is an important tool that enables the Department to achieve the right balance of military, civilian, and contractor personnel. We have worked hard with the Service Secretaries, the Service Surgeons General and their respective staffs to identify, select, and execute viable conversions that will ultimately benefit the Department and, most importantly, the beneficiary. Overall, I believe we have been successful in this endeavor.

I support the GAO's recommendation that a consistent full-cost methodology for comparing the cost of military and civilian personnel be utilized, and for requiring documentation to support assertions regarding the potential effects of planned conversions on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental personnel. However, there are some inaccuracies in the GAO report that are addressed in both our comments to the recommendation and in our technical comments.

My points of contact on this audit are Mr. Jon Rychalski (Functional) at (703) 681-4693, and Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-4360.

Sincerely,



S. Ward Casscells, MD

Enclosures:
As stated

**Government Accountability Office (GAO) Draft Report Dated JANUARY 7, 2008
GAO-08-370R (GAO CODE 351087)**

**“MILITARY PERSONNEL: GUIDANCE NEEDED FOR ANY FUTURE
CONVERSIONS OF MILITARY MEDICAL POSITIONS TO CIVILIAN
POSITIONS”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE RECOMMENDATION**

RECOMMENDATION: To help ensure that the Military Departments provide Congress with reasonable assurances that any future conversions would not increase costs or decrease access to care and quality of care, we recommend that the Secretary of Defense direct the Under Secretary of Defense (Personnel and Readiness) (USD (P&R)), in coordination with the Assistant Secretary of Defense (Health Affairs) (ASD (HA)), and Service Secretaries, to develop operating guidance for the Military Departments to use when justify future conversions of military medical and dental positions to civilian positions. This guidance should stipulate requirements to:

1. Utilize a consistent full-cost methodology for comparing the cost of military and civilian personnel, as we had recommended in our May 2006 report; and
2. Provide documentation to support assertions regarding the potential effects of planned conversions on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental personnel.

RESPONSE:

1. We support a standard methodology for comparing the full costs of military and civilian personnel. It is important to note, however, that using the full cost of military personnel may have the consequence of making military medical conversions more compelling because the cost of military manpower would be even more expensive as compared to civilians. In most certifications to date, a composite rate (not full cost) was generally used which resulted in an extremely conservative outcome. Full-costing will likely drive a business case to pursue more conversions. Additionally, the Government Accountability Office (GAO) has erred in assigning this responsibility exclusively to USD (P&R) and ASD (HA). USD (P&R)'s directive on manpower management implements 10 United States Code (U.S.C.) §129a by requiring Department of Defense (DoD) Components to “use the least costly form of personnel (military, civilian and contractor) consistent with military requirements and other needs of the Department.” USD (P&R) also issues instructions for determining the appropriate workforce mix. However, the Under Secretary of Defense (Comptroller) (USD (C)), and the Director, Program Analysis and Evaluation (PA&E), are responsible for developing the tools and guidance necessary for determining the costs of military, civilian, and contractor personnel. For this reason, the GAO should include USD (C) and PA&E as responsible

parties in completing Recommendation 1. Until this is completed, USD (C) composite rates are being used, in conjunction with guidance from PA&E on additional cost factors, to fully account for costs of Government personnel.

2. We agree that the Military Departments should provide rationale for their conclusions, as appropriate. However, it's important to recognize that there are many variables affecting quality, access, and cost of health care that are unrelated to military-to-civilian conversions. In many cases it's impossible to isolate the impact that conversions have from the impact that these other factors have on health care. Decisions concerning the effects of military medical conversions will always entail a degree of judgment on the part of the health care community and must be made in consideration of the Department's overall approach to managing its workforce. For example, the Department routinely rotates military medical and dental personnel at military treatment facilities (MTFs) to other assignments within the Department and replaces civilian personnel who retire or separate. This is all managed without adverse consequences to health care delivery. As a result, it is not unreasonable for the Military Departments to presume that quality and access to care will not be adversely impacted by the conversion of military medical and dental personnel, so long as civilian replacements are fully qualified, the rate of conversion is in keeping with the military rotation rate, the fill rate of vacated positions is fairly consistent with the routine fill rates at the MTFs, and requirements for skill levels are not changed at the time of the conversions.

GAO Contact and Staff Acknowledgments

GAO Contact

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Acknowledgments

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(351087)

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